Release of Information Authorization

Client Name:	
Client Date of Birth:	
Client Phone Number:	
Client Driver's License Number & Issuing State/Authority*:	

***** If client does not have a driver's license, a state/federal identification card number, military identification card number, or passport number may be entered above.

This authorization form is used to release and/or to obtain your protected health information (PHI) as required by federal and state privacy laws. Your authorization allows HopeWay Psychiatry & Associates to release/to obtain your PHI to/from a person or entity that you choose. You may withdrawal this authorization at any time by submitting a written request to HopeWay (contact the Health Information Management Department at 980-203-4616 or HIM@hopeway.org for assistance). Withdrawal of this authorization will not affect any action taken prior to receipt of your written request.

SERVICES RECEIVED FROM:

HopeWay Psychiatry & Associates

5925 Carnegie Boulevard, Suite 525, Charlotte, NC 28209

4014 Monroe Road, Suites 250, 260, & 270, Charlotte, NC 28205

1717 Sharon Road West, Charlotte, NC 28210

1835 Sharon Road West, Charlotte, NC 28210

SECTION I: REQUESTING/RELEASING PARTY INFORMATION

I request and authorize HopeWay: ☐ To release to: ☐ To obtain from:

Person / Entity Name: _____

Address, City, State, Zip: _____

Phone Number: _____ Fax Number: _____

Email: _____

SECTION II: METHOD OF TRANSMISSION

☐ Verbal ☐ Written ☐ Electronic

SECTION III: TYPES OF INFORMATION TO BE RELEASED (Please, be **specific** when indicating types of information to be released.)

☐ Presence & Progress in Treatment
☐ History & Physical
☐ Psychiatric Assessment & History
☐ Psychiatric & Medical Progress Notes
☐ Substance Use Assessment & History
☐ Individual & Group Therapy Notes
☐ Biopsychosocial Assessment & History
☐ Laboratory/Pharmacogenetics/Imaging Results
☐ HIV/AIDS Test Results and Treatment Information
☐ Aftercare Recommendations/Discharge Plan
☐ Registered Dietitian Notes
☐ Psychological Testing
☐ Discharge Summary
☐ Billing/Financial Information
☐ Other:_____

☐ Education/School Forms, Letters, Documents

☐ Reproductive Health Test Results and Treatment Information

DATE RANGE:_____(e.g., "All dates of service" or "01/20/2023 to 01/25/2024".)

SECTION IV: PURPOSE FOR THE RELEASE

The above information is being requested for release for the purpose of:

☐ Client Use/Client Request
☐ Financial/Payment/Insurance
☐ Continuity of Care/Evaluation/Treatment
☐ Social Security/Disability Claiming
☐ Unemployment Claiming
☐ Employment/School Continuity
☐ Legal Purposes
☐ Special Forms/Letters
☐ Other:_____

SECTION V: EXPIRATION OF AUTHORIZATION

I understand that this authorization is valid and will terminate **3 years** from the date of signature.

SECTION VI: REFUSAL TO SIGN

I understand that I may refuse to sign this authorization. I understand that my refusal to sign will not affect my ability (1) to obtain health care services or (2) affect my ability for treatment, payment, enrollment in a health plan or eligibility for benefits.

SECTION VII: SIGNATURE & AUTHORIZATION

Records released may contain alcohol/drug treatment information, psychiatric/psychological information, pharmacogenetics information, HIV/AIDS information, reproductive health information, and/or related conditions. HopeWay and many other organizations and individuals such as physicians, hospitals, and health plans are required by law, inclusive of HIPAA and 42 CFR Part 2 (as applicable to alcohol/drug treatment information), to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

Client (or Legal Representative) Signature: _____

Date: _____

If signed by Legal Representative, relationship to client: _____

Printed Name of Legal Representative: _____

SECTION VIII: WITHDRAWAL OF AUTHORIZATION

I understand that I have a right to withdraw this authorization at any time. I understand that if I withdraw this authorization, I must do so in writing and present my written withdrawal to the releasing person/agency. I understand that the withdrawal will not apply to information that has already been released in response to this authorization.

Version Date: 01.27.2025